Frederick County Health Access Program

An Initiative of the Frederick County Health Care Coalition
In Partnership with the Frederick County Health Department

Providing Connections to Care

Ph. 301-788-8592 FAX 866-430-9751

PROVIDER PARTICIPATION AGREEMENT

This is to acknowledge my agreement to participate in the Frederick County Health Access Program by accepting _____ enrollees into my practice each _____(month or year).

I understand that once a patient is either assigned to my primary care practice or referred to my specialty practice, I will care for that patient until care is no longer needed or until he/she is no longer enrolled in FCHAP.

I understand that patients will present a FCHAP ID card and pre-pay a visit fee of $15. I may see enrollees who have not paid the visit fee at my discretion.

I/my office staff will complete the standard "fee ticket" form documenting each enrollee's visit, routine charges, prescriptions, ordered follow-up tests or referrals and have it faxed to FCHAP following each visit.

I have received the list of labs/diagnostics to be provided at no cost to patients at FMH sites. Lab/diagnostic orders will be given to patients but also noted on the faxed fee form so that the case manager can assist patients to obtain tests in a timely manner. (Covered labs/diagnostic tests done within your office setting will be reimbursed at Medicare rates. Please circle or note on the fee ticket those tests completed in the office; reimbursement will be forwarded to you.)

I will note the need for specialist referrals on the fee form; I understand that once an enrollee has been assigned to the needed specialist, my practice will be notified and I will forward any pertinent referral information to the specialist.

I have received the formulary for reduced cost generic medications and will order medications from this list whenever medically appropriate.

I will report to the FCHAP Coordinator any concerns with patient compliance, payment of visit fees, or visit etiquette.

The Frederick County Access Program will publicly recognize and thank participating providers on a regular basis. If you do not wish to be recognized, please sign here:

_____

My participation in this program will renew annually unless I choose to terminate it by notifying the FCHAP Program Coordinator.

_____ _____

Provider Signature/Printed Name Date

_____ _____

Program Coordinator Date